Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-280
Employees' Manual, Title 8
Medicaid Appendix

November 16, 2007

AREA EDUCATION AGENCY MANUAL TRANSMITTAL NO. 07-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***AREA EDUCATION AGENCY MANUAL***, Title Page, revised; Table of Contents, new; Chapter III, *Provider-Specific Policies*, Title Page, new; Table of Contents (pages 1 and 2), new; pages 1 through 43, new; and the following forms:

CMS-1500 *Health Insurance Claim Form*, revised
470-3969 *Claim Attachment Control*, revised
RA-1500 *Remittance Advice*, revised
470-3816 *Medicaid Billing Remittance*, new

Summary

Chapters on coverage and limitations and on billing and payment for family planning services are combined and revised to reflect the implementation of the Iowa Medicaid Enterprise and the reorganization of the Medicaid "All Providers" manual chapters.

Within the manual, the form samples have been removed from the numbered pages and connected to the on-line manual through hypertext links. This will make the chapters quicker to load on line and easier to read and update.

This release:

- Clarifies that a license from the Iowa Department of Public Health is required for an audiologist or speech-language pathologist to be covered by Medicaid.
- Clarifies language by eliminating references to an individual family service plan (IFSP). This program relates to individual education plan (IEP) services only.
- Clarifies that audiometrist services are not billable to Medicaid.
- Clarifies that teaching Braille is an educational service and is not covered by Medicaid.
- Reflects a change in coding for psychologist service due to revised CPT codes.
- Clarifies that the child's actual diagnosis must be submitted on the claim form.
- Transmits the revised Billing Remittance form.

Date Effective

June 1, 2007

Material Superseded

Remove the entire Chapter E and Chapter F from the ***AREA EDUCATION AGENCY MANUAL*** and destroy them. This includes the following:

Page	Date
Title Page	Undated
Contents (Page 4)	October 1, 2003
Contents (Page 5)	July 1, 2003
Chapter E	
1	September 1, 2002
2	October 1, 2003
2a, 3	July 1, 2004
4	October 1, 2003
5, 6	July 1, 2004
7, 8	March 1, 1996
9, 10	July 1, 2004
11, 12	October 1, 2003
13	July 1, 2004
14	March 1, 1996
15, 16	July 1, 2004
17-19	March 1, 1996
20, 21	July 1, 2004
22	October 1, 2003
23, 24	September 1, 2000
25-27	July 1, 2004
28-31	October 1, 2003
Chapter F	
1-3	March 1, 1998
4	July 1, 2003
5-7	March 1, 1998
8	July 1, 2003
9, 10 (HCFA-1500)	12/90
10a (470-3969)	7/03
11, 12	March 1, 1998
13 (Remittance Advice)	June 12, 1997
14	No date
15-17	March 1, 1998
18	July 1, 2003
19 (470-3744)	10/02
20	No date
21 (470-0040)	10/02
22	No date
23	September 1, 2002
24 (470-3828)	5/02

Additional Information

The updated provider manual containing the revised pages can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise Provider Services Unit.

Medicaid Enterprise

Iowa Department of Human Services

Area Education Agency Provider Manual

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. AGENCIES ELIGIBLE TO PARTICIPATE

An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa Department of Education.

B. COVERAGE OF SERVICES

Iowa Medicaid payment will be made for medically necessary audiological, nursing, occupational therapy, physical therapy, psychological, speech-language, social work, and vision services provided by an area education agency. Screening, assessment, and direct services are covered.

These services shall be provided by personnel who meet the standards as set forth in Iowa Department of Education rule 281 Iowa Administrative Code 41.8(256B,34CFR300), to the extent that their certification or license allows them to provide these services.

Practitioners shall meet the Department of Education licensure and endorsement or recognition requirements for the position for which they are employed. Additionally, practitioners are required to hold a professional or occupational license, certificate, or permit if they do not hold a Department of Education licensure.

1. Records Required

Maintain fiscal and clinical records in support of each item of service for which a charge is made to the Iowa Medicaid program. Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment of Medicaid payment. The fiscal record does not constitute a clinical record.

As a condition of accepting Medicaid payment for services, you must provide the Iowa Medicaid program access to client medical records when requested. Make the medical and fiscal records available to the Department or its duly authorized representative on request.

Respect client rights of confidentiality in accordance with the provisions of 42 CFR Part 431, Subpart F, and Iowa Code Section 217.30.

a. Treatment Plan

All services must be specific to a Medicaid-eligible student who has an individual educational plan (IEP). A treatment plan (IEP) based on professional assessment is required for all services billed to Medicaid. The treatment plan must indicate measurable goals and objectives and the type and frequency of services provided.

An updated treatment plan that delineates the need for ongoing services is required annually. The updated plan must:

- Include the student's current level of functioning.
- Set new goals and objectives when needed.
- Delineate the modified or continuing type and frequency of service.

b. Clinical Records

Maintain complete and legible clinical records documenting that the services for which a charge is made to the Medicaid program are:

- Medically necessary,
- Consistent with the diagnosis of the student's condition, and
- Consistent with professionally recognized standards of care.

Your documentation for each encounter shall include the following information necessary to support each item of service reported on the Medicaid claim form (as applicable):

- Complaint and symptoms; history; examination findings; diagnostic test results; assessment, clinical impression or diagnosis; plan for care; date; and identification of the observer.
- Specific procedures or treatments performed.
- Medications or other supplies dispensed.
- The student's progress, response to and changes in treatment, and revision of diagnosis.

2. Audiological Services

The following services are covered when they are included in the IEP or are linked to a service in the IEP:

- Audiological screening
- Individual audiological assessment
- Direct audiological service to an individual
- Direct audiological service in a group
- Contracted audiological therapy services

To be covered by Medicaid, audiological services, including contracted audiological services, must be provided by a licensed audiologist.

a. Audiological Screening

A licensed audiologist must perform hearing screening. Objective audiological screening must be performed in both ears:

- Using a pure-tone audiometer at a minimum of 500, 1000, 2000, and 4000 Hz.
- At a maximum of 25 dB HL at any one frequency.

If a student fails to respond at any of the four frequencies in either ear, a complete audiogram or other assessment must be done.

b. Individual Audiological Assessment

Individual audiological assessment includes tests, tasks, and interviews used to:

- Identify hearing loss in students.
- Establish the nature, range, and degree of the hearing loss.
- Make referral for medical or other professional attention for the habilitation of hearing.

c. Direct Audiological Service to an Individual

Direct audiological service to an individual is provided in a 1:1 therapist-to-student ratio. The type and level of treatment services are a direct outcome of the assessment. Services may be provided directly to the student or through case consultation.

Direct service includes:

- **Auditory training**: Sound discrimination tasks (in quiet noise), sound awareness, and sound localization.
- **Audiology treatment**: Services to students and their families, including:
  - Rehabilitative services to hearing-impaired students, including language habilitation, auditory training, speech reading (lip reading), speech conservation, and ongoing hearing evaluation.
  - Counseling and guidance of students, parents, and teachers regarding hearing loss and the proper care and use of amplification.
  - Determination of the student's need for group and individual amplification (hearing aids, auditory trainers, and other types of amplification).
  - Selection and fitting appropriate amplification.
  - Monitoring the functioning of the student's hearing aid or other amplification.
  - Evaluation of the effectiveness of amplification.
  - Adjustment or modification of hearing aids and other amplification.
  - Repair of amplification.
  - Making recommendation for new hearing aids or other amplification.

The role of **consultation** is monitoring, supervising, teaching, and training professionals, paraprofessionals and parents in the educational, home, or community environment.

Case consultation includes:

- Providing general information about a specific student's handicapping condition.
- Teaching special skills necessary for proper care of a specific student's hearing aid.
- Developing, maintaining, and demonstrating use and care of adaptive or assistive devices for a specific student.
- Making recommendations for enhancing a specific student's performance in education environments.

d. Direct Audiological Service in a Group

Direct audiological service provided in a group is identical in scope to the direct service activities listed under direct services to an individual, except that services are provided to a group of students not to exceed a 1:5 school audiologist-to-student ratio.

e. Contracted Audiological Therapy Services

Contracted audiological therapy services include screening, assessment and therapy services that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, educational certification or licensure, and medical necessity remain unchanged.

3. Nursing Services

Nursing services include but are not limited to:

- Health assessments and evaluations.
- Diagnosis and planning.
- Administering and monitoring medical treatments and procedures.
- Consultation with licensed physicians and other health practitioners, parents, and staff regarding medications.
- Individual health counseling and instruction.
- Emergency intervention.
- Other activities and functions within the purview of the Nurse Practice Act.

Medicaid covers the following services when they are in the IEP or are linked to a service in the IEP and are provided by a licensed nurse:

- Screening
- Individual assessment
- Direct services to an individual
- Direct services to a group
- Contracted nursing service

a. Screening

Screening is the process of assessing health status through direct individual or group observation, in order to identify problems and determine if further assessment is needed.

b. Individual Assessment

"Assessment" refers to the process of health data collection, observation, analysis, and interpretation for the purpose of formulating a nursing diagnosis. The initial assessment includes:

- Determining the need, nature, frequency, and duration of treatment.
- Determining the need for coordinating with other service.
- Documentation of these activities.

Other activities include:

- **Treatment planning**: Establishing a plan of care that includes determining goals and priorities for actions that are based on the nursing diagnosis and the intervention to implement the plan of care.
- **Monitoring of treatment implementation**: Activities designed to document whether the plan of care is meeting the child's needs by demonstrating maintenance or improvement in health status.
- **Evaluation**: Activities designed to evaluate the child's state in relation to established goals and the plan of care.

c. Direct Nursing Service to an Individual

Services to an individual student involve executing the individual nursing interventions in the plan of care, including ongoing assessment, planning, intervention and evaluation.

d. Direct Nursing Service to a Group

Services to a group may include:

- **Group counseling**. This service is designed to improve the students' health status.
- **Family counseling**. This service consists of sessions with one or more family members for the purposes of effecting change within the family structure to ensure the student's health needs are met.

e. Contracted Nursing Service

Contracted services include nursing assessment and direct services to an individual or a group that are rendered by a qualified practitioner who is a contractor, rather than an employee of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

f. Nursing Care Procedures

Services include but are not limited to immunizations, medication administration and monitoring, prescribed health procedures, and interventions identified in the treatment plan.

Nursing procedures required for specialized health care under 281 Iowa Administrative Code 41.96(256B) include but are not limited to:

- Catheterization:
  - Education and monitoring self catheterization
  - Intermittent urinary catheterization
  - Indwelling catheter irrigation, reinsertion, and care
- Feeding:
  - Nutrition and history assessment
  - Ostomy feeding
  - Ostomy irrigation, insertion, removal, and care
  - Parenteral nutrition (intravenous)
  - Specialized feeding procedures
  - Stoma care and dressing changes

- Health support systems:
  - Apnea monitoring and care
  - Central line care, dressing change, emergency care
  - Dressing and treatment
  - Dialysis monitoring and care
  - Shunt monitoring and care
  - Ventilator monitoring, care, and emergency plan
  - Wound and skin integrity assessment, monitoring, and care
- Medications: (281 Iowa Administrative Code 41.12(11) and 41.96)
  - Administration of medications—by mouth, injection (intravenous, intramuscular, subcutaneous), oral inhalation by inhaler or nebulizer, rectum or bladder instillation, eye, ear, nose, skin, ostomy, or tube
  - Ongoing assessment of medications
  - Medication assessment and emergency administration
- Ostomies:
  - Ostomy care, dressing, and monitoring
  - Ostomy irrigation
- Respiratory care:
  - Oxygen monitoring and care
  - Postural drainage and percussion treatments
  - Suctioning
  - Tracheostomy tube replacement
  - Tracheostomy monitoring and care
  - Ventilator care
- Specimen collection:
  - Blood
  - Sputum
  - Stool
  - Urine
- Other nursing procedures:
  - Bowel and bladder intervention, monitoring, and care
  - Assessing and monitoring body systems, vitals, and growth and development

4. Occupational Therapy

The following occupational therapy services are covered when they are in the IEP or are linked to a service in the IEP:

- Occupational therapy screening
- Individual occupational therapy assessment
- Direct occupational therapy service to an individual
- Direct occupational therapy service in a group
- Contracted occupational therapy services

To be covered, the service must be provided by:

- A licensed occupational therapist, or
- A licensed occupational therapy assistant as delegated and supervised by the licensed occupational therapist.

a. Occupational Therapy Screening

Screening is the process of surveying a student through direct and indirect observation in order to identify previously undetected problems. Screening may include, but is not limited to, the use of any of the following methods:

- Review of written information (school or medical records, teacher notes).
- Review of spoken information (interview teachers or parents).
- Direct observation (checklists, a comparison with peers).
- Formal screening tools.

Occupational therapists may be involved in screening a group of students, but more typically, the therapist consults and provides in-service for other school personnel who regularly screen groups of students.

b. Individual Occupational Therapy Assessment

An assessment by an occupational therapist should consider information from each of the following areas as they affect the student's ability to meet the demands of the educational program:

- Developmental motor level
- Neuromuscular and musculoskeletal components
- Functional motor skills:
  - Self-care
  - Mealtime skills
  - Manipulation skills

c. Direct Occupational Therapy Service

Direct occupational therapy to an individual includes services indicated in the treatment plan. Occupational therapy service may be provided through the following models.

(1) Direct Service Model

In a direct service model, the therapist works with a student individually. Therapy may occur in an isolated environment due to the need for instruction free from distraction or the need for specialized equipment not found in the classroom setting.

The therapist or an assistant under the supervision of the therapist is the primary provider of service and is accountable for specific treatment plan short-term objectives for the student. There is not an expectation that activities will be delegated to others and carried out between therapy sessions.

The emphasis of direct therapy is usually on the acquisition of basic motor or sensorimotor patterns or sequences needed for new motor performance during a critical learning period. The student has not achieved a level of ability that would permit transfer of skills to other environments.

Typically, direct service is used when frequent program changes are needed and other personnel do not have the unique expertise to make these decisions. The therapist's professional judgment determines when a licensed therapist is the only person qualified to carry out the therapy program.

Intervention sessions may include the use of therapeutic or specialized equipment that require the therapist's expertise and cannot safely be used by others within the student's educational environment.

Often, only a short interval of direct service is needed before the student can participate in a less restrictive model of service.

(2) Integrated Service Model

The integrated therapy service model combines direct student-therapist contact with consultation with others involved in the student's educational program.

Emphasis is placed on the need for practice of motor skills and problem solving in the student's daily routine. Integrated therapy service is provided within the student's daily educational environment.

The process of goal achievement is shared among those involved with the student, including the therapist, therapist assistant, teacher, parents, classroom associate, and others. Intervention may include:

- Adapting functional activities, usually occurring in the student's routine related to mobility, self-care, mealtime skills, or manipulation.
- Creating opportunities for the student to practice new motor skills.
- Dynamic positioning.
- Collaborative problem solving with others to encourage motor functioning and independence.

Only the actual time spent providing service by the therapist or an assistant under the supervision of a therapist is considered therapy. Activities or follow-through performed by others cannot be called occupational therapy.

(3) Consultative Service Model

In the consultative occupational therapy service model, the therapist participates in collaborative consultation with the teacher, other staff, parents, and, when appropriate, the student regarding student-specific issues as identified in the IEP goals and objectives.

Occupational therapy appears on the IEP as a support service and is associated with a specific IEP goal or objective.

The therapist's unique expertise is often needed for staff and parent training related to the IEP goal or objective. Although the therapist is not the primary person responsible for carrying out these activities, the therapist's input is typically needed to determine:

- Appropriate expectations.
- Environmental modifications.
- Assistive technology.
- Possible learning strategies.

The intervention activities, which are delegated to others, do not require the therapist's expertise and should not be identified as occupational therapy.

d. Direct Occupational Therapy Service in a Group

Direct occupational therapy to a group includes the same models as described for direct occupation therapy service to an individual.

e. Contracted Occupational Therapy Services

Contracted occupational therapy services include screening, assessment and therapy services that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

5. Physical Therapy

The following physical therapy services are covered when they are in the IEP or are linked to a service in the IEP:

- Physical therapy screening
- Individual physical therapy assessment
- Direct physical therapy service to an individual
- Direct physical therapy service in a group
- Contracted physical therapy services

To be covered, the service must be provided either by:

- A licensed physical therapist, or
- A licensed physical therapist assistant as delegated and supervised by the licensed physical therapist.

a. Physical Therapy Screening

Screening is the process of surveying a student through direct and indirect observation in order to identify previously undetected problems. Screening may include, but is not limited to, the use of any of the following methods:

- Review of written information (school or medical records, teacher notes).
- Review of spoken information (interview teachers or parents).
- Direct observation (checklists, a comparison with peers).
- Formal screening tools.

Physical therapists may be involved in screening a group of students, but more typically, the therapist consults and provides in-service for other school personnel who regularly screen groups of students.

b. Individual Physical Therapy Assessment

An assessment by a physical therapist should consider information from each of the following areas as they affect the student's ability to meet the demands of the education program:

- Developmental motor level
- Neuromuscular and musculoskeletal components
- Functional motor skills:
  - Positioning
  - Mobility

Other areas may also be considered when they are related to the student's identified problem.

c. Direct Physical Therapy to an Individual

Direct physical therapy to an individual includes services indicated in the treatment plan. Physical therapy service may be delivered through the following models:

(1) Direct Service Model

In a direct service model, the therapist works with a student individually. Therapy may occur in an isolated environment due to the need for instruction free from distraction or the need for specialized equipment not found in the classroom setting.

The therapist or an assistant under the supervision of the therapist is the primary provider of service and is accountable for specific treatment plan short-term objectives for the student. There is not an expectation that activities will be delegated to others and carried out between therapy sessions.

The emphasis of direct therapy is usually on the acquisition of basic motor or sensorimotor patterns or sequences needed for new motor performance during a critical learning period. The student has not achieved a level of ability that permits transfer of skills to other environments.

Typically, direct service is used when frequent program changes are needed and other personnel do not have the unique expertise to make these decisions. The therapist's professional judgment determines when a licensed therapist is the only person qualified to carry out the therapy program.

Intervention sessions may include the use of therapeutic or specialized equipment that require the therapist's expertise and cannot safely be used by others within the student's educational environment.

Often, only a short interval of direct service is needed before the student can participate in a less restrictive model of service.

(2) Integrated Service Model

The integrated service model combines direct student-therapist contact with consultation with others involved in the student's educational program. The process of goal achievement is shared among those involved with the student, including the therapist, therapist assistant, teacher, parents, classroom associate, and others.

Integrated therapy service is provided within the student's daily educational environment. Emphasis is placed on the need for practice of motor skills and problem solving in the student's daily routine. Intervention may include:

- Adapting functional activities, usually occurring in the student's routine related to mobility.
- Creating opportunities for the student to practice new motor skills.
- Dynamic positioning to promote learning.
- Collaborative problem solving with others to encourage motor functioning and independence.

Only the actual time spent providing service by the therapist, or assistant under the supervision of a therapist, is considered therapy. Activities or follow-through performed by others cannot be called physical therapy.

(3) Consultative Service Model

In the consultative service model, the therapist participates in collaborative consultation with the teacher, other staff, parents, and when appropriate the student regarding student-specific issues as identified in the treatment plan goals and objectives.

Physical therapy appears on the treatment plan as a support service and is associated with a specific treatment plan goal or objective, although the therapist is not the primary individual responsible for carrying out these activities.

The therapist's unique expertise is often needed for staff and parent training related to the treatment plan goal or objective. The therapist's input is typically needed to determine:

- Appropriate expectations.
- Environmental modifications.
- Assistive technology.
- Possible learning strategies.

The intervention activities, which are delegated to others, do not require the therapist's expertise and should not be identified as occupational therapy.

d. Direct Physical Therapy Service in a Group

Direct physical therapy to a group includes the same models as described under direct physical therapy service to an individual.

e. Contracted Physical Therapy Services

Contracted physical therapy service include screening, assessment and therapy services which are rendered by a qualified practitioner who is a contractor, rather than an employee, of the provider. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

6. Psychological Services

The following psychological services are covered when they are in the IEP or are linked to a service in the IEP:

- Psychological screening
- Individual psychological assessment
- Direct psychological service to an individual
- Direct psychological service in a group
- Contracted psychological service

To be covered, services must be provided by a licensed or certified school psychologist.

a. Psychological Screening

Psychological screening is the process of surveying a student through direct observation or group testing in order to verify problems and determine if further assessment is needed.

b. Individual Psychological Assessment

"Assessment" refers to the process of collecting data for the purpose of making treatment decisions. The initial assessment includes:

- Determining the need, nature, frequency, and duration of treatment.
- Deciding the needed coordination with others.
- Documenting these activities.

Other activities include:

- **Treatment planning**: Assessment activities and procedures used to design an intervention plan.
- **Monitoring of treatment implementation**: Assessment activities and procedures designed to document student improvement during treatment provision and to adjust the intervention plan as needed.
- **Treatment evaluation**: Assessment activities and procedures designed to evaluate the summary effects of an intervention after a significant period.

c. Direct Psychological Service to an Individual

Direct psychological services to an individual involve individual therapy and consist of supportive, interpretive, insight-oriented, and directive interventions.

d. Direct Psychological Service in a Group

Direct psychological services to a group include the following services:

- **Group therapy** that is designed to enhance a student's socialization skills, peer interaction, expression of feelings, etc.
- **Family therapy**, which consists of sessions with one or more family members for the purposes of effecting changes within the family structure, communication, clarification of roles, etc.

e. Contracted Psychological Services

Contracted psychological services include individual psychological assessment and direct psychological services to an individual or in a group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

7. Social Work Services

Social work services include assessment, diagnosis and treatment services including, but not limited to:

- Administration and interpretation of clinical assessment instruments.
- Psychosocial history.
- Obtaining, integrating, and interpreting information about child behavior.
- Planning and managing a program of therapy or intervention services.
- Providing individual, group, or family counseling.
- Providing emergency or crisis intervention services.
- Consultation services to assist other service providers or family members in understanding how they may interact with a child in a therapeutically beneficial manner.

Medicaid covers the following services when they are in the IEP or are linked to a service in the IEP and a licensed school social worker or guidance counselor provides them:

- **Screening**. Screening is the process of surveying a student through direct observation or group testing in order to verify problems and determine if further assessment is needed.
- **Individual assessment**. "Assessment" refers to the process of collecting data for the purpose of making treatment decisions. The initial assessment includes:
  - Determining the need, nature, frequency, and duration of treatment.
  - Deciding the needed coordination with others.
  - Documenting these activities.

  Additional activities include:
  - **Treatment planning** means establishing treatment goals and procedures used to design an intervention plan.
  - **Monitoring of treatment implementation** means activities and procedures designed to document student progress during treatment provision and to adjust the treatment plan as needed.
  - **Treatment evaluation** means activities designed to evaluate the effects of an intervention after a significant period.
- **Direct service to an individual**. Services to an individual student involve individual therapy, which may utilize any model of therapy and clinical practice.
- **Direct service in a group**. Services to a group include the following therapeutic and related services:
  - **Group therapy**. This service is designed to enhance socialization skills, peer interaction, expression of feelings, etc.
  - **Family therapy**. This service consists of sessions with one or more family members, for the purposes of effecting changes within the family structure, communication, clarification of roles, etc. The student must be present when family therapy is provided.
- **Contracted service**. Contracted services include clinical assessment and direct services to an individual or in a group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

8. Speech-Language Therapy

The following speech-language services are covered when they are in the IEP or are linked to a service in the IEP:

- Speech-language screening
- Individual speech-language assessment
- Direct speech-language service to an individual
- Direct speech-language service in a group
- Contracted speech-language service

To be covered, services must be provided by either:

- A licensed or certified speech-language pathologist, or
- A speech pathology assistant who is supervised by a licensed speech-language pathologist.

NOTE: Contracted speech-language services are covered only when provided by a licensed or certified speech-language pathologist.

a. Speech-Language Screening

Speech-language screening is the process of surveying a student through direct supervision by a speech-language pathologist in order to identify previously undetected speech and language problems such as:

- Articulation
- Receptive and expressive language
- Voice
- Fluency
- Oral motor functioning
- Oral structure

b. Individual Speech-Language Assessment

Individual speech-language assessment refers to the process of gathering and interpreting information through:

- The administering of tests or evaluative instruments.
- Observation.
- Record review.
- Interviews with parents, teachers, and others.

Results of the assessment may identify delay or disorder in one or more of the following areas:

- Articulation
- Language
- Fluency
- Voice
- Oral motor, feeding, or both

Based on these assessments, the student's needs are identified, planned for, and documented, including the amount of services.

c. Direct Speech-Language Service to an Individual

Speech-language services include various service delivery models. All models may be used independently, in combinations, or with minor variations.

(1) Indirect Service Delivery Models

Indirect service delivery models indicate services provided to a student through the parent, teacher, or others in the student's environment, rather than by direct, routine contact with a speech-language pathologist.

- **Consultation** is used to remediate speech-language impairments by providing information, materials, demonstration teaching, and bibliotherapy, usually through parents and teachers.
- The **parents** or other caregivers of a student with speech-language impairments are organized with the specific goal to provide information and material support as indicated in the IEP.

(2) Direct Service Delivery Models

The following direct service delivery models may be used for speech-language services:

- **Center-based classroom for speech-language impairments** (CM): A class, at any level, taught by a qualified speech-language pathologist, for students with a speech-language impairment as their primary handicapping condition.

  Students receive special education weighting. The curriculum is communication-based and is directed toward remediating the speech-language impairment. Classes can be either full-day or half-day programs. Special transportation may be required.

- **Communication class**: A class period taught by a speech-language pathologist. The curriculum is designed to remediate and improve speech-language skills and to augment regular classroom activities.

- **Episodic intervention** (distributive practice): A flexible management strategy in terms of methods selected, length of intervention, frequency of intervention, and duration of management strategies. In the distributive practice model, the service provider may vary.

- **Extended-year special education** (EYSE): An extended school year for students who are selected based on empirical and qualitative data demonstrating that an interruption in programming will result in loss of critical skills that cannot be retaught in nine weeks or that a rare and unusual circumstance exists.

- **Home based**: Speech-language services in which a speech-language pathologist goes to the student's home to provide one-on-one services to remediate the speech-language impairment or provide demonstration to parents.

- **Hospital**: Speech-language services that are carried out by a speech-language pathologist in a medical setting. This usually involves referral for diagnostic work-ups for independent opinions or to gain additional information. It may also involve monitoring and management of speech-language impairments.

- **Individual**: One-on-one speech-language services provided by a speech-language pathologist or communication aide. This may occur in a variety of environments, such as a "pull out" setting, in the classroom or in the community.
- **Itinerant home services**: Service to students who are temporarily unable to leave home to attend school due to illness or other disability. Various models may be used, such as individual or consultation.
- **Learning center**: Six to ten students with speech-language impairments work independently in a group setting under the direction of a speech-language pathologist.

  The speech-language pathologist provides materials, monitoring, reinforcement, and feedback to the students, and may provide brief periods of individual instruction as needed.
- **Pull out** (individual or group): Students are taken from their primary educational setting (classrooms) to work with a speech-language pathologist or communication aide on IEP goals designed to remediate their speech-language impairment. In some cases, a student may be scheduled for both individual and group speech-language services.

d. Direct Speech Therapy Service in a Group

(1) Indirect Service Delivery

Services are provided to a student through the parent, teacher, or others in the student's environment rather than by direct, routine contact with a speech-language pathologist.

In a **parent group**, a group of parents or other caregivers of students with speech-language impairments is organized with the specific goal of providing information and material support.

(2) Direct Service Delivery Models

- **Center-based classroom**: Defined the same as for individual service delivery.
- **Communication class**: Defined the same as for individual service delivery.

- **Extended-year special education** (EYSE): Defined the same as for individual service delivery.
- **Large group**: Four or more students seen by the speech-language pathologist or communication aide in a classroom or "pull-out" model in which there is group interaction.
- **Small group**: Two to four students seen by the speech-language pathologist or communication aide in a classroom or "pull-out" model in which there is group interaction.
- **Integrative, collaborative, team teaching**: A model used for students with a speech-language impairment served in a coordinated fashion by the speech-language pathologist and the teacher and, in some cases, other professionals.

  The IEP indicates various single and dual responsibilities for each team member. In some instances, speech-language activities are integrated into curriculum activities.
- **Pull out** (individual or group): Defined the same as for individual service delivery.
- **Special education programs**: For students, including preschool students, who have such a severe speech-language impairment (CM) that an instructional program is needed in addition to speech-language services. Those students may be placed in a disability-specific or multicategorical special education class.

  Because the speech-language impairment is the student's primary handicapping condition, the IEP must reflect the greatest intervention for that disability.

  The IEP must reflect goals and objectives directed to remediating the speech-language problem as carried out by the teacher and the speech-language pathologist. In most cases, an adjusted program report must be filed.

e. Contracted Speech-Language Services

Contracted speech-language services include screening, assessment, and therapy services that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

9. Vision Services

Vision services include:

- Identification of the range, nature, and degree of vision loss.
- Consultation with a student and parents concerning the student's vision loss and appropriate selection, fitting or adaptation of vision aids.
- Evaluation of the effectiveness of a vision aid.
- Orientation and mobility services.

Medicaid covers the following services when they are they are in the IEP or are linked to a service in the IEP and are provided by personnel who are licensed or certified to provide vision services:

- **Vision screening**. Screening is the process of assessing vision through direct observation in order to identify problems and determine if further assessment is needed.
- **Vision assessment**. Assessment refers to the process of collecting data for the purpose of making treatment decisions. Assessment activities include:
  - Determining the need, nature, frequency, and duration of treatment.
  - Determining the need for coordination with other providers.
  - Documenting these activities.
- **Direct services to an individual**. Individual intervention is designed to enhance vision or orientation and mobility skills of an individual student.
- **Direct services to a group**. Group services involve two or more students and are designed to enhance vision or orientation and mobility skills of the group.

- **Contracted vision services**. Contracted service include vision assessment and direct services for an individual or group which are rendered by a qualified practitioner who is a contractor, rather than an employee of the agency. The requirements for documentation, records maintenance, and medical necessity remain the same.

10. Service Exclusions

The following services shall not be covered:

- Services (including screening and assessment) that are provided but are not documented in the student's IEP unless the service is directly linked to a service included in the IEP.
- Initial evaluation and reevaluations.
- Treatment plan (IEP) development.
- Services rendered that are not provided directly to the eligible student or to a family member on behalf of the eligible student.
- Consultation services that are not specific to an eligible student or are not consistent with the treatment plan.
- Canceled visits or appointments that are not kept.
- Services that are **solely** instructional in nature.
- Services that are **solely** recreational in nature.
- Services provided under Section 504 of the Rehabilitation Act of 1973. NOTE: Teaching Braille is considered an educational service.
- Services provided to students over the age of 20.

C. BASIS OF PAYMENT

Area education agencies are reimbursed based on a fee schedule. The amount billed should reflect the actual cost of providing the services. The fee schedule amount is the maximum payment allowed.

Bill all procedures in whole units of service. For most codes, 15 minutes equals one unit. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit.

D. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied. Use the diagnosis code V70-5 (health examination of defined subpopulation) on all claims.

In certain instances, two-digit modifiers are applicable. They should be placed after the five-position procedure code. Possible modifiers are shown below:

Modifier	Definition
AH	Clinical psychologist
AJ	Social worker
GN	Speech pathologist
GO	Occupational therapist
GP	Physical therapist
HQ	Group setting
TD	RN
TE	LPN
TM	Individual education program – contracted services
UA	Audiologist

Procedure codes applicable to area education agency services are as follows:

Code	Modifier	Description
Audiology		
V5008		Hearing screening per encounter
92506	UA	Evaluation of speech, language, voice, communication, auditory processing, or aural rehabilitation status 15-minute unit
92507	UA	Treatment of speech, language, voice, communication, or auditory processing disorder; individual, 15-minute unit
92507	TM	Treatment of speech, language, voice, communication, or auditory processing disorder; individual, by contracted staff
92508	UA	Treatment of speech, language, voice, communication, or auditory processing disorder; group, 15-minute unit

Code	Modifier	Description
Nursing Service		
T1023	TD or TE	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter. (TD = RN TE = LPN)
T1001		Nursing assessment/evaluation, per 15-minute unit
T1002		RN services, per 15-minute unit
T1002	HQ	RN services, group, 15-minute unit
T1002	TM	RN services, contracted services, 15-minute unit
T1003		LPN services, per 15-minute unit
T1003	HQ	LPN services, group, 15-minute unit
T1003	TM	LPN services, contracted services, 15-minute unit
H0033		Oral medication administration, 15-minute unit
99199		Unlisted service, 60-minute unit
Occupational Therapy		
T1023	GO	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.
97003		Occupational therapy evaluation, 15-minute unit
97150	GO	Therapeutic procedures, group, 15-minute unit
97530	GO	Therapeutic activities, direct patient contact by the provider, 15-minute unit
97530	TM	Therapeutic activities, direct patient contact by the provider, contracted staff, 15-minute unit
97535	GO	Self-care or home management training, 15-minute unit
97535	TM	Self-care or home management training by contracted staff, 15-minute unit
97537	GO	Community or work reintegration, 15-minute unit
97537	TM	Community or work reintegration by contracted staff, 15-minute unit
Orientation and Mobility		
97139		Unlisted therapeutic procedure

Code	Modifier	Description
Physical Therapy		
T1023	GP	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.
97001		Physical therapy evaluation, per 15-minute unit
97116		Gait training, per 15-minute unit
97116	TM	Gait training by contracted staff, 15-minute unit
97150		Therapeutic procedures, group, per 15-minute unit
97530		Therapeutic activities, direct patient contact by the provider, 15-minute unit
97530	TM	Therapeutic activities, direct patient contact by the provider, by contracted staff, 15-minute unit
97535		Self-care or home management training, per 15-minute unit
97535	TM	Self-care or home management training by contracted staff, 15-minute unit
97537		Community or work reintegration, per 15-minute unit
97537	TM	Community or work reintegration by contracted staff, 15-minute unit
Psychological Services		
T1023	AH	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.
96100		Psychological testing with interpretation and report, per 60-minute unit
90804	AH	Individual psychotherapy, 30-minute unit
90804	TM	Individual psychotherapy by contracted staff, 30-minute unit
90853	AH	Group psychotherapy, 30-minute unit
Social Work – Counseling Services		
T1023	AJ	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol; per encounter.
H0031		Mental health assessment by non-physician, per 15-minute unit
90804	AJ	Individual psychotherapy, 30-minute unit
90853	AJ	Group psychotherapy, 30-minute unit
H0046	TM	Mental health services, not otherwise specified, by contracted staff, per 15-minute unit

Code	Modifier	Description
Speech Language		
V5362		Speech screening per encounter
V5363		Language screening per encounter
92506	GN	Evaluation of speech, language, voice, communication, auditory process, and aural rehabilitation status; per 15-minute unit
92507	GN	Treatment of speech, language, voice, communication, or auditory processing disorder; individual, per 15-minute unit
92507	TM	Treatment of speech, language, voice, communication, or auditory processing disorder; individual by contracted staff, per 15-minute unit
92508	GN	Treatment of speech, language, voice, communication, or auditory processing disorder; group, per 15-minute unit
Vision Service		
99172		Visual function screening automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination for contrast sensitivity vision under glare); 15 minute unit
99173		Screening test of visual acuity, quantitative, bilateral, 15-minute unit
92012		Ophthalmological services, exam and evaluation, 15-minute unit
92014		Comprehensive services, established patient, 15-minute unit
92014	TM	Comprehensive services, established patient by contracted staff, 15-minute unit
92499		Unlisted service (vision services in a group setting), 15-minute unit

E. CLAIM FORM

Claims for area education agency services are billed on federal form CMS-1500, *Health Insurance Claim Form*. To view a sample of this form on line, click here.

1. Instructions for Completing the CMS-1500 Claim Form

The table below follows the CMS-1500 claim form by field number and name, and gives a brief description of the information to be entered and whether providing information in that field is required, optional, or conditional of the individual member's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**REQUIRED**. Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED**. Enter the Medicaid member's Medicaid number, found on the *Medical Assistance Eligibility Card*. The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	**REQUIRED**. Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	**OPTIONAL**. Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	**OPTIONAL**. For Medicaid purposes, the "insured" is always the same as the patient. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	**OPTIONAL**. Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**OPTIONAL**. For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	**OPTIONAL**. For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	**REQUIRED, IF KNOWN**. Check boxes corresponding to the patient's current marital and occupational status.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
9a-d.	OTHER INSURED'S NAME	**SITUATIONAL**. Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	**REQUIRED, IF KNOWN**. Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL**. No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**OPTIONAL**. For Medicaid purposes, the "insured" is always the same as the patient.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**REQUIRED**. If the Medicaid member has other insurance, check "yes" and enter the payment amount in field 29. If "yes," then boxes 9a-9d must be completed. If there is no other insurance, check "no." If you have received a denial of payment from another insurance, check **both** "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. NOTE: Auditing will be performed on a random basis to ensure correct billing.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL**. No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL**. No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	**SITUATIONAL**. Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	**SITUATIONAL**. Chiropractors must enter the current X-ray as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	**OPTIONAL**. No entry required.
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL**. Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the health care provider that directed the patient to your office.
17a.		**OPTIONAL**. No entry required.
17b.	NPI	**SITUATIONAL**. If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit national provider identifier (NPI) of the referring provider. If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized the service, enter that provider's NPI.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
18.	HOSPITALIZATION DATES RELATED TO...	**OPTIONAL**. No entry required.
19.	RESERVED FOR LOCAL USE	**OPTIONAL**. No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL**. No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED**. Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary, 2-secondary, 3-tertiary, and 4-quaternary), to a maximum of four diagnoses. If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	**SITUATIONAL**. If there is a prior authorization, enter the prior authorization number. Obtain this number from the prior authorization form.
24. A	DATE(S) OF SERVICE	**REQUIRED**. Enter month, day, and year under both the "From" and "To" columns for each procedure, service, or supply. If the "From-To" dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a monthly basis, spanning or overlapping billing months could cause the entire claim to be denied.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. B	PLACE OF SERVICE	**REQUIRED**. Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	EMG	**OPTIONAL**. No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED**. Enter the codes for each of the dates of service. **Do not** list services for which no fees were charged. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	**REQUIRED**. Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. **Do not** write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED**. Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	**REQUIRED**. Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**SITUATIONAL**. Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	**OPTIONAL**. No entry required.
24. J	RENDERING PROVIDER ID #	**SITUATIONAL**. The "rendering provider" is the practitioner who provided, supervised, or ordered the service. In the lower portion, enter the NPI of the provider rendering the service when the NPI given in field 33 is that of a group or is not that of the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL**. No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
26.	PATIENT'S ACCOUNT NUMBER	**FOR PROVIDER USE**. Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or numeric characters.
27.	ACCEPT ASSIGNMENT?	**OPTIONAL**. No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED**. Enter the total of the line-item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**SITUATIONAL**. Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	**REQUIRED**. Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED**. Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	**REQUIRED**. Enter the name and address associated with the rendering provider.
32a.	NPI	**OPTIONAL**. Enter the NPI of the facility where services were rendered.
32b.		**OPTIONAL**. No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
33.	BILLING PROVIDER INFO AND PHONE #	**REQUIRED**. Enter the complete name and address of the billing provider or service provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered. NOTE: The ZIP code must match the ZIP code confirmed during NPI verification or during enrollment. To view the ZIP code provided, access imeservices.org.
33a.	NPI	**REQUIRED**. Enter the ten-digit NPI of the billing provider. A provider that does not meet the definition of "health care provider" and therefore does not meet the criteria to receive an NPI should enter the ten-digit provider number assigned by IME (begins with "X00"). If this number identifies a group or an individual provider other than the provider of service, the rendering provider's NPI must be entered in field 24J for each line. NOTE: The NPI must match the NPI confirmed during NPI verification or during enrollment. To view the NPI provided, access imeservices.org.
33b.		**REQUIRED**. Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment. To view the taxonomy code provided, access imeservices.org.

2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- **Complete** form 470-3969, *Claim Attachment Control*. To view a sample of this form on line, click here. Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number.

Iowa Department of Human Services

Iowa Medicaid Program

Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

Attachment Control Number

Provider Name _____

NPI Billing Provider Number

Member Name _____

Member State ID Number

Date of Service _____/_____/_____

Type of Document

_____

_____

_____

Return this document with attachments to:

IME Claims
P.O. Box 150001
Des Moines, IA 50315

470-3969 (Rev. 7/07)

If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.

- **Staple** the additional information to the *Claim Attachment Control*. Do **not** attach a paper claim.
- **Mail** the *Claim Attachment Control* with attachments to:

  Iowa Medicaid Enterprise
  PO Box 150001
  Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

F. REMITTANCE ADVICE

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- **Denied** represents all processed claims for which no reimbursement is made.
- **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click here.

NO.	FIELD NAME	DESCRIPTION
1.	To:	Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2.	R.A. No.:	Remittance Advice number.
3.	Warr No.:	The sequence number on the check issued to pay this claim.
4.	Date Paid:	Date claim paid.
5.	Prov. Number:	Billing provider's Medicaid (Title XIX) number.
6.	Page:	*Remittance Advice* page number.
7.	Claim Type:	Type of claim used to bill Medicaid.

IAMC8000-R001 (CP-O-12)
AS OF 10/22/07

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 10/19/07

R E M I T T A N C E A D V I C E

TO: (1) R.A. NO.: 3(2)6 WARR NO.: 9(3)9 DATE PAID: 10/22/07 (4) PROV. NUMBER: (5) PAGE: (6) 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* * * CLAIM TYPE: HCFA 1500 (7)								* * * CLAIM STATUS: PAID (8)					
ORIGINAL CLAIMS: (9)			(11)			(12)	(13)	(14)	(15)	(16)			(17)
		(10)	3-07290-00-015-0941-00		(21)	172.00	0.00	85.07	1.00				000 000
		(18) 01	(19) 10/04/07	99242 (20)	1	172.00	(22)	85.07 (24)	1.00 (25)	(26)		F	000 000
							(23)						
			3-07292-00-009-0053-00			69.00	0.00	32.36	0.00	(27)			000 000
		01	07/06/07	99212	1	69.00		32.36	0.00			F	000 000
			3-07288-00-010-0484-00			298.00	0.00	145.03	0.00				000 000
		01	07/11/07	99212 25	1	69.00		32.36	0.00			F	000 000
		02	07/11/07	29405	1	197.00		112.67	0.00			F	000 000
		03	07/11/07	A4590	1	32.00		0.00	0.00			K	177 000
			0-07281-22-009-0270-00			128.00	0.00	71.46	0.00				000 000
		01	06/14/07	20550	1	122.00		68.06	0.00			F	000 000
		02	06/14/07	J3301	2	6.00		3.40	0.00			F	000 000
4 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..						667.00	0.00	333.92	1.00				

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 2

**** PATIENT NAME **** LAST	FIRST	MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* * * CLAIM TYPE: HCFA 1500									* * * CLAIM STATUS: DENIED					
ORIGINAL CLAIMS:														
				3-07289-00-011-0880-00			69.00	0.00	0.00	0.00			499	000
			01	07/12/07	99212	1	69.00		0.00	0.00			K 000	000
1 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..							69.00	0.00	0.00	0.00				

TO: R.A. NO.: 3438496 WARR NO.: 9999999 DATE PAID: 10/22/07 PROV. NUMBER: PAGE: 3

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REMITTANCE T O T A L S					
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	4	---------	667.00	333.92
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	1	---------	69.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	---------	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	---------	0.00	0.00
AMOUNT OF CHECK:					333.92

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE: COUNT:

29

177 THE PROCEDURE/SERVICE BILLED HAS BEEN DETERMINED TO BE NONCOVERED FOR THE DATE OF SERVICE SHOWN ON THE CLAIM. 1

499 INVALID OR MISSING MEDIPASS REFERRAL FOR RECIPIENT. 1

NO.	FIELD NAME	DESCRIPTION
8.	Claim Status:	Status of following claims: • **Paid**. Claims for which reimbursement is being made. • **Denied**. Claims for which no reimbursement is being made. • **Suspended**. Claims in process. These claims have not yet been paid or denied.
9.	Patient Name	Member's last and first name.
10.	Recip ID	Member's Medicaid (Title XIX) number.
11.	Trans-Control-Number	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
12.	Billed Amt.	Total charges submitted by provider.
13.	Other Sources	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
14.	Paid by Mcaid	Total amount of Medicaid reimbursement as allowed for this claim.
15.	Copay Amt.	Total amount of member copayment deducted from this claim.
16.	Med Recd Num	Medical record number as assigned by provider; 10 characters are printable.
17.	EOB	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for explanation of the EOB code.
18.	Line	Line item number.
19.	SVC-Date	The first date of service for the billed procedure.
20.	Proc/Mods	The procedure code for the rendered service.
21.	Units	The number of units of rendered service.
22.	Billed Amt.	Charge submitted by provider for line item.
23.	Other Sources	Amount applied to this line item from other resources, i.e., other insurance, spenddown.

NO.	FIELD NAME	DESCRIPTION
24.	Paid by Mcaid	Amount of Medicaid reimbursement as allowed for this line item.
25.	Copay Amt.	Amount of member copayment deducted for this line item.
26.	Perf. Prov.	Treating provider's Medicaid (Title XIX) number.
27.	S	Allowed charge source code: **B** Billed charge **F** Fee schedule **M** Manually priced **N** Provider charge rate **P** Group therapy **Q** EPSDT total screen over 17 years **R** EPSDT total under 18 years **S** EPSDT partial over 17 years **T** EPSDT partial under 18 years **U** Gynecology fee **V** Obstetrics fee **W** Child fee
28.	Remittance totals	(Found at the end of the *Remittance Advice*): • Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of paid adjusted claims, amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of denied original claims and the amount billed by the provider. • Number of denied adjusted claims and the amount billed by the provider. • Number of pended claims (in process) and the amount billed by the provider. • Amount of the check (warrant) written to pay these claims.
29.	Description of EOB code	Lists the individual explanation of benefits codes used, followed by the meaning of the code and advice.

MEDICAID BILLING REMITTANCE

[provider]

Provider # [ ] Invoice # [ ] Date [ ]

The provider's share of the cost of the [provider] services. For the month of [month and year] your agency received $[amount]. The total amount owed as the non-federal share is $[amount] [For AEA only add: and 75% of the federal share for a total of $(amount)]. This form must accompany payment for proper crediting.

All payments should be made to the Iowa Department of Human Services at the following address:

DHS Cashier 1st FL.
1305 E. Walnut St.
Des Moines IA 50319-0114

The amount of _____ for the month of _____ is enclosed.

Signature of Authorized Representative Date

Agency Name

If you have questions or concerns please contact Sally Nadolsky at snadols@dhs.state.ia.us or (515)725-1142. Payment is due within 30 days of the date of this notice. Thank you for your assistance and timely payment.

cc: DHS, DE

G. MEDICAID BILLING REMITTANCE

The IME uses form 470-3816, *Medicaid Billing Remittance*, to notify providers of the amount of the non-federal share of the Medicaid reimbursement paid to the provider in the previous month. To view a sample of this form on line, click here. It also includes the total of the non-federal share and 75% of the federal share.

Please send the payment for the non-federal share within 30 days of the date on the form. This form must accompany the payment for proper crediting.

- List the dollar amount of the non-federal share to be certified.
- List the month and year that the agency was paid.
- Enter an authorized signature and date.
- Enter the name of agency.

There will be detailed information provided with this form for your information.